No. 93-1251

In The

Supreme Court of the United States

October Term, 1993

DONNA E. SHALALA, SECRETARY OF HEALTH AND HUMAN SERVICES,

Petitioner,

v.

GUERNSEY MEMORIAL HOSPITAL,

Respondent.

On Petition For A Writ Of Certiorari To The Sixth Circuit Court Of Appeals

BRIEF FOR THE RESPONDENT IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Petitioner has presented the following questions:

1. Whether general Medicare record-keeping and reporting regulations require that provider costs be reimbursed according to "generally accepted accounting principles," despite contrary administrative rules issued by the Secretary of Health and Human Services to govern reimbursement of particular types of costs.

2. Whether, if the regulations do not impose such a requirement, the provision of the Medicare Provider Reimbursement Manual on which the Secretary relied in denying reimbursement in this case is invalid as a legislative rule issued without compliance with the notice-and-comment provisions of the Administrative Procedure Act.

The above issues arise from a dispute involving Medicare reimbursement for the costs incurred by Respondent in connection with the advance refunding of bonded indebtedness. It is undisputed that the Respondent is entitled to Medicare reimbursement for the costs in question. The parties, however, dispute when the reimbursement is to be made – in a lump sum in the year of the refunding as required by generally accepted accounting principles ("GAAP") and the Medicare regulations requiring the use of GAAP, or in a series of payments amortized over the remaining life of the refunded bonds as required by Provider Reimbursement Manual Section 233 ("PRM 233").

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JURISDICTION

Respondent does not take issue with the Petitioner invoking the jurisdiction of this Court under 28 U.S.C. § 1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

In addition to the statutes and regulations restated in the Petition for a Writ of Certiorari:

1. Section 1871 of the Social Security Act, 42 U.S.C. § 1395hh(a), provides as follows:

> (1) The Secretary shall prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter. When used in this subchapter, the term "regulations" means, unless the context otherwise requires, regulations prescribed by the Secretary.
>
> (2) No rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits under this subchapter shall take effect unless it is promulgated by the Secretary by regulation under paragraph (1).

2. The Medicare regulation implementing 42 U.S.C. § 1395x(v)(1)(A), 42 C.F.R. Part 413, provides in pertinent part as follows:

> **Subpart A – Introduction and General Rules**
>
> **§ 413.5 Cost Reimbursement: General**
>
> (a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne

> by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. * * *
>
> (b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:
>
> (1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement. . . .

STATEMENT OF THE CASE

Respondent takes issue with Petitioner's characterization of the loss on advance refunding as an "accounting" loss. The loss incurred in 1985 by Respondent in defeasing its 1972 and 1982 bonds was an actual loss. *Mercy Hosp. v. Sullivan*, Medicare & Medicaid Guide (CCH) ¶ 40,227 (D. Me. 1991).

Indeed, there is no dispute in this case that the loss was incurred by Respondent as an actual cost of providing medical services to Medicare beneficiaries since Petitioner agrees that the loss is reimbursable. The advance refunding loss includes the write-off of approximately $700,000 of unamortized bond discount and financing costs associated with the 1972 and 1982 bond issues. PRRB Hearing Decision, Appendix to Petition for a Writ of Certiorari (hereinafter "Appendix to Petition"), 56a-57a. These costs were actually paid in full by Respondent in 1972 and 1982, and amortized as interest costs by Respondent over the periods during which Respondent was obligated under the 1972 and 1982 bond issues, which obligations expired in 1985 with the defeasance. The advance refunding loss also includes the payment of a call premium on the 1982 bonds in the approximate amount of $300,000, which Respondent had to fund out of pocket at the time of the defeasance in 1985. Indeed, Petitioner, at footnote 4 of her Petition for a Writ of Certiorari, admits that the call premium was "payable to holders when the bonds were called by the escrow trustee in 1992, but funded in advance by respondent's payment into the escrow account" in 1985. Netted against the unamortized bond discount and financing costs and the call premium costs was approximately $300,000 in interest income earned by the escrow fund for the 1972 and 1982 bonds. The net advance refunding loss of $672,581 represents actual expenses incurred by Respondent in 1985. These expenses related only to the 1972 and 1982 obligations which were defeased in 1985. For GAAP and Medicare reimbursement purposes these costs must be

reported and reimbursed in full in 1985, the year of defeasance.

Respondent also takes issue with Petitioner's statement that the Provider Reimbursement Review Board ("PRRB") did not directly address the validity of PRM 233. The PRRB specifically observed that "PRM section 233, also used by the Intermediary to disallow the loss, breaks down the loss into components and presents individual reimbursement treatments for each component." PRRB Hearing Decision, Appendix to Petition, 70a. The PRRB rejected the Intermediary's use of PRM 233 because the PRRB found that the loss, "as incurred, is allowable under 42 C.F.R. 405.451 [42 C.F.R. § 413.9] – the cost was reasonable, necessary and proper, and related to patient care," and that "[t]he loss was related to patient care in 1985, the year of defeasance." *Id.* at 70a-71a.

Respondent further emphasizes that it is undisputed that the entire amount of the advance refunding loss in issue is an allowable expense for Medicare reimbursement purposes. *See* Decisions of the U.S. Court of Appeals for the Sixth Circuit and the U.S. District Court for the Southern District of Ohio, Appendix to Petition, 2a, 19a-20a. Only the timing of reimbursement is disputed in this case. The District Court's decision reflects this understanding as follows:

> The general principles for cost reimbursement are set forth in 42 C.F.R. § 413.5, which provides that "[a]ll necessary and proper expenses of an institution in the production of services . . . are recognized." The parties agree that the refinancing cost incurred by Guernsey Hospital is a cost

> which is reimbursable under this general principle. As noted above, the disagreement involves the timing of reimbursement.

District Court Decision, Appendix to Petition, 19a-20a.

The Respondent notes that the court of appeals also stated that the general reimbursement provisions of Part 413 of the Medicare regulations required payment of advance refunding loss in the year of defeasance, relying specifically on the following language from 42 C.F.R. § 413.5(b)(1):

> the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

Sixth Circuit Decision, Appendix to Petition, 7a.

REASONS FOR DENYING THE PETITION

Respondent Guernsey Memorial Hospital respectfully requests that this Court deny the Petition for a Writ of Certiorari seeking review of the decision of the United States Court of Appeals for the Sixth Circuit in this case. Contrary to Petitioner's arguments, the court of appeals' decision does not conflict with the decision of any other court of appeals and the court of appeals' approach in interpreting the Medicare regulations does not present serious or disruptive implications for the administration of the Medicare program.

The Petitioner has misstated the holding of the court of appeals. The court of appeals did not hold that the Secretary has effectively delegated to the accounting profession her ultimate authority to determine the amount of reimbursement due a hospital under the Medicare program. Whether the underlying cost is reimbursable is not at issue in this case. The timing of reimbursement is at issue. With respect to this issue, the court of appeals determined, quoting the PRRB decision in this case, that the Medicare regulation

> 42 C.F.R. § 413.24 requires that cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. Under the accrual basis of accounting, expenses are to be reported in the period in which they are incurred, regardless of when paid. Under the accrual basis of accounting, the loss on defeasance was incurred in the period when the bonds were de[illegible]sed. The majority of the Board believes that [illegible] C.F.R. § 413.24 requires that the Secretary determine cost on the accrual basis unless a specific regulation to the contrary has been promulgated.

Sixth Circuit Decision, Appendix to Petition, 13a.

The decision of the court below is consistent with the applicable Medicare statutes and regulations and with the overwhelming weight of authority interpreting those statutes and regulations.

There Is No Conflict Among the Circuit Courts of Appeals

The court of appeals' decision that Medicare regulations require the use of accrual accounting and GAAP principles to determine the period in which costs are reimbursed and that accrual accounting principles and GAAP require that the loss on defeasance be recognized in the year of defeasance does not conflict with the decision of any other court of appeals. Petitioner attempts to create a conflict among the courts of appeals by misstating the decision of the court of appeals in this case. At page 11 of the Petition for a Writ of Certiorari, Petitioner states that "[t]he court of appeals' holding rests on its conclusion that two of the Secretary's general Medicare reimbursement regulations, 42 C.F.R. 413.20 and 413.24, mandate the use of GAAP to determine *allowable* costs, unless the Secretary has promulgated a more specific regulation dealing with a particular cost issue." (emphasis added) Petitioner confuses the issue of cost allowability with the issue of the timing of reimbursement for allowable costs. The court of appeals' decision states that it is undisputed that the defeasance costs in question are allowable, but that there is a dispute as to the timing of reimbursement. Sixth Circuit Decision, Appendix to Petition, 2a.

Petitioner cites the decisions of the courts of appeals in *National Medical Enterprises, Inc. v. Sullivan*, 916 F.2d 542 (9th Cir. 1990), *cert. denied*, ___ U.S. ___, 111 S.Ct. 2014, 59 U.S.L.W. 3769 (1991); *Sun Towers, Inc. v. Heckler*, 725 F.2d 315, *cert. denied*, 469 U.S. 823 (1984); *Richey Manor, Inc. v. Schweiker*, 684 F.2d 130 (D.C. Cir. 1982); *North Clackamas Community Hosp. v. Harris*, 664 F.2d 701

(9th Cir. 1980); and *Methodist Hosp. of Indiana, Inc. v. United States*, 626 F.2d 823 (Ct. Cl. 1980), as in conflict with the decision below. The decisions cited by Petitioner address whether or not a certain type of cost is allowable. Specifically, *Sun Towers, Inc.* and *National Medical Enterprises* determined that stock maintenance costs were not reimbursable costs because they were not related to patient care as required by 42 C.F.R. § 413.9. Similarly, *Richey Manor, Inc.* determined that stock purchase expenses were not reimbursable costs because they were not related to patient care.[1] *North Clackamas Community Hosp.* disallowed Medicare reimbursement for that portion of the purchase price of a facility that was allocated to the going concern value because a specific Medicare regulation, 42 C.F.R. § 413.157(b), provided that payment for good will was not a reasonable cost allowable by the Medicare program. Finally, *Methodist Hosp.* determined that pension costs, although generally allowable, were properly disallowed in the case before it because the hospital had failed to comply with the required accrued pension trust document. The court in *Methodist Hosp.* found that the hospital's failure to comply with the pension trust document meant that the hospital "did not actually incur the pension cost." *Methodist Hosp.*, 626 F.2d at 825. The *Methodist Hosp.* court expressly limited its holding to that situation in which the hospital violated the pension plan funding requirements. *Id.* at 825, n. 8.

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[1] The United States District Court for the District of Columbia in *The Methodist-Evangelical Hosp., Inc. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 42,017 (D.D.C. 1993), rejected the Secretary's argument that *Richey Manor, Inc.* supports the Secretary's position in the advance refunding issue before this Court.

Each of the cases cited by Petitioner as being in conflict with the decision below addresses the issue of reimbursability. In this case the reimbursability of the advance refunding costs is not in dispute. As recently stated by the district court in *The Methodist-Evangelical Hosp., Inc., supra*, at 8: "[E]ach of these cases determines reimbursability *vel non*; none addresses the timing of reimbursement. *Guernsey* teaches that GAAP governs reimbursement timing and is what is at issue here."

Indeed, in footnote 9 of the Petition for a Writ of Certiorari, Petitioner admits that there is not a conflict among the courts of appeals regarding the application of GAAP in the context of advance refunding transactions. Rather than a conflict, a consensus exists among the federal courts on the application of GAAP in advance refunding transactions. The following federal courts have considered the precise legal issue before the court below and have held consistent with the court below that Medicare regulations require the application of GAAP in advance refunding transactions: *The Methodist-Evangelical Hosp., Inc., supra*; *Graham Hosp. Ass'n v. Sullivan*, 832 F. Supp. 1235 (C.D.Ill. 1993); *St. John's Hosp. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,700 (E.D. Mich. 1993); *Baptist Hosp. East v. Sullivan*, 767 F. Supp. 139 (W.D. Ky. 1991); *Mercy Hosp., supra*; *Ravenswood Hosp. Medical Ctr. v. Schweiker*, 622 F. Supp. 338 (N.D.Ill. 1985). The only decision of a federal court to affirm the Secretary's amortization of advance refunding costs is *Mother Frances Hosp. v. Shalala*, 818 F.Supp. 990 (E.D.Tex. 1993).[2] The

[2] The decision in *Mother Frances Hosp.* is pending before the Fifth Circuit Court of Appeals. Contrary to the Petitioner's argument, however, there is no reason to believe that the Fifth Circuit will affirm this decision on the basis of its decision in *Sun Towers, Inc., supra*. As explained above, *Sun Towers, Inc.* involved the issue of allowable costs rather than the issue of timing for the reimbursement of allowable costs.

PRRB[3] also has consistently taken the position that Medicare regulations require the application of GAAP in advance refunding transactions.[4]

In short, it is obvious that there is no conflict at all among the circuit courts on this issue. Rather, federal courts have consistently ruled that the Medicare regulations require that an advance refunding loss be reimbursed in the year of the defeasance.

[3] The PRRB is a board "composed of five members . . . knowledgeable in the field of payment of providers of services" created by the Medicare statute to mediate Medicare disputes. 42 U.S.C. § 1395oo(h).

[4] The PRRB decided in favor of the provider in each of the advance refunding cases decided by the district courts, which have been cited in the text above. The PRRB also has decided in favor of the provider in the following cases, which present the identical issue present in this case: *Dominican Santa Cruz Hosp., Santa Cruz, Ca. v. Blue Cross*, Medicare & Medicaid Guide (CCH) ¶ 40,120 (PRRB 1990); *Michigan Osteopathic Medical Ctr. v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 40,369 (PRRB 1992); *Fort Worth Osteopathic Medical Ctr. v. Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 40,413 (PRRB 1991); *St. Mary's Regional Medical Ctr. v. Aetna Life Ins. Co.*, Medicare & Medicaid Guide (CCH) ¶ 41,583 (PRRB 1993); *University of Michigan Hosps. v. Blue Cross & Blue Shield Ass'n*, Medicare & Medicaid Guide (CCH) ¶ 41,743 (PRRB 1993).

The Decision of the Court of Appeals Is Consistent With the Medicare Act and Regulations

Petitioner argues that her application of PRM 233 finds support in that portion of the Medicare Act defining reasonable cost, 42 U.S.C. § 1395x(v)(1)(A). The Petitioner's argument, however, is without merit because Section 1395x(v)(1)(A) directs the Petitioner to promulgate regulations to determine reasonable cost and, in promulgating such regulations, to consider the "principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment. . . . "

The Petitioner has promulgated such regulations at 42 C.F.R. Part 413, and those regulations expressly adopt "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields," and provide that "[c]hanges in these practices and systems will not be required in order to determine costs payable under the principles of reimbursement." 42 C.F.R. § 413.20(a). The regulations also provide that "cost data must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(a). These provisions and other provisions of the Medicare cost reimbursement regulations at 42 C.F.R. Part 413 have been consistently interpreted by the courts to require the use of GAAP in determining the timing of Medicare cost reimbursement in the absence of a regulation to the contrary. *See HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d 1179 (9th Cir. 1989); *Charlotte Memorial Hosp. & Medical Ctr. v.*

Bowen, 860 F.2d 595 (4th Cir. 1988); *Lexington County Hosp. v. Schweiker*, 740 F.2d 287 (4th Cir. 1984); *Villa View Community Hosp. v. Heckler*, 720 F.2d 1086 (9th Cir. 1983); *The Methodist-Evangelical Hosp., Inc., supra; St. John's Hosp., supra; Baptist Hosp. East, supra; Mercy Hosp., supra; Ravenswood Hosp. Medical Ctr., supra; Cabrini Medical Ctr. v. Schweiker*, Medicare & Medicaid Guide (CCH) ¶ 30,961 (D.D.C. 1981); and *Ornda Healthcorp v. Shalala*, Medicare & Medicaid Guide (CCH) ¶ 41,975 (E.D. Ark. 1993). PRM 233 departs from the accrual method of accounting and GAAP by deferring reimbursement for advance refunding costs to periods after those costs were incurred. PRM 233 thus conflicts with the Medicare regulations defining reasonable cost by providing for reimbursement of costs which are no longer incurred by the provider.

Petitioner attempts to confuse the issue before this Court by proclaiming that the national organizations contemplated by the Medicare Act's definition of reasonable cost were health oriented organizations such as the American Hospital Association ("AHA"), rather than national accounting organizations. Petitioner relies upon AHA publications as support for her argument that GAAP is not mandated by the regulations. These publications, however, do not support the Petitioner's position. To the contrary, as noted by Petitioner at footnote 10 of the Petition for a Writ of Certiorari, the AHA *Principles of Payment for Hospital Care* states that "[t]he determination of reimbursable cost requires acceptance and use of uniform definitions, accounting, statistics, and reporting." This concept is virtually identical to the language of 42 C.F.R. § 413.20(a), which states "[s]tandardized definitions, accounting, statistics, and reporting practices that

are widely accepted in the hospital and related fields are followed." Likewise, the "Purpose and Scope" section of AHA *Uniform Chart of Accounts and Definitions for Hospitals* (1959), which is cited by Petitioner in her Petition at pp. 16-17, reveals that the AHA has adopted the accrual basis of accounting.

Similarly, the comments of Social Security Commissioner Ball, as reflected at page 198 of Appendix D to the 1966 *Congressional Hearing on Principles of Medicare Reimbursement*, confirm that "the determination of reimbursable cost does require the acceptance and use of uniform definitions, accounting, statistics, and reporting." The accrual basis of accounting required by the AHA and adopted by Petitioner in her regulations at 42 C.F.R Part 413 support the decision of the court of appeals in this action.

The Petitioner's argument that the regulations relied on by the court below provide no support for its holding ignores the plain language of 42 C.F.R. §§ 413.5, 413.20, and 413.24. Section 413.5(b)(1) of "Cost Reimbursement: General," which Petitioner fails to discuss as a basis for the holding below, identifies the following objective of cost reimbursement:

> That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

The amortization requirement of PRM 233 directly contradicts the current payment requirement of Section 413.5. It is undisputed in this case that the Respondent

has paid the costs at issue prior to or in the year of the bond defeasance. It is further undisputed that the defeasance released all obligation of the Respondent under the defeased bonds. The loss on advance refunding was incurred in the year of defeasance to secure release from Respondent's obligation under the defeased bonds. Once all obligations of Respondent were released, there were no costs related to the defeased bonds that could be ascribed to periods after the defeasance.

The amortization requirement of PRM 233 likewise contradicts Section 413.20(a), which requires that "[s]tandardized definitions, accounting, statistics, and reporting practices that are widely accepted in the hospital and related fields" will be followed, and that "[c]hanges in these practices and systems will not be required in order to determine costs *payable* under the principles of reimbursement." (emphasis added) This regulatory provision means that the Medicare program must pay reimbursable costs based on GAAP principles. Section 413.20(a) further provides that costs are determined from the provider's "basic accounts, as usually maintained." Once a refunded debt has been extinguished, it no longer appears as an obligation on the provider's books and there are no costs to the provider in future years related to this obligation or the refunding transaction. PRM 233 would create an accounting fiction not required by GAAP or the Petitioner's regulations.

The Petitioner's suggestion that 42 C.F.R. § 413.20 is ambiguous is not supported by any authority. Indeed, none of the many courts reviewing this regulation has found it ambiguous. *See Charlotte Memorial Hosp. & Medical Ctr., Inc., supra; Villa View Community Hosp., Inc., supra;*

St. John's Hosp., supra; The Methodist-Evangelical Hosp., Inc., supra; Baptist Hosp. East, supra; Mercy Hosp., supra; Ornda Healthcorp, supra; and *Ravenswood Hosp. Medical Ctr., supra*. Likewise, the PRRB, the board created by the Medicare Act to resolve reimbursement disputes, has consistently found the plain language of Section 413.20 to require current reimbursement of advance refunding losses in every advance refunding case before it.[5] Finally, there is no authority for Petitioner's argument that the language of Section 413.20 should be disregarded because that regulation, as originally enacted, was placed at the end of a series of prefatory sections of the initial Medicare regulations.

The amortization requirement of PRM 233 also contradicts 42 C.F.R. § 413.24(a), which provides that Medicare cost data "must be based on an approved method of cost finding and on the accrual basis of accounting." 42 C.F.R. § 413.24(b)(2) states: "Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid." Under the accrual basis of accounting advance refunding losses are incurred in the year of the refinancing.

The Petitioner's suggestion that GAAP embodies a "particular version" of accrual accounting is without any support. Accrual accounting is the standardized basis of

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[5] *Dominican Santa Cruz Hosp., Santa Cruz, Ca., supra; Michigan Osteopathic Medical Ctr., supra; Fort Worth Osteopathic Medical Ctr., supra; St. Mary's Regional Medical Ctr., supra; University of Michigan Hosps., supra.*

revenue and cost reporting. It is standardized so that costs of different organizations and of different periods will be comparable.[6] There are no "versions" of accrual accounting. The suggestion that different versions of accrual accounting exist has never been made prior to the Petition for a Writ of Certiorari. To the contrary, it has been "undisputed in the case at bar that Guernsey Memorial Hospital keeps its books on the accrual basis of accounting." Sixth Circuit Decision, Appendix to Petition, 7a. The *post hoc* rationalizations of appellate counsel cannot be accepted as support for Petitioner's departure from the accrual basis of accounting. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988).

The Petitioner's argument that Section 413.24 speaks only to the manner in which information must be "reported" in a provider's books, and not to the manner in which the data derived from those books will be analyzed by the Secretary in determining allowable costs in a given period ignores the plain language of the regulation. Section 413.24, by its terms, governs "cost finding" for Medicare reimbursement purposes. As explained by the regulation: "Cost finding is the process of recasting

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[6] Similarly, the Petitioner's suggestion that Section 233 is consistent with accrual accounting because prior to the adoption of Accounting Principles Board Opinion No. 26 ("APB 26") there was some support among the accounting profession for the amortization of bond defeasance costs is without merit. As stated in APB 26, the Opinions of the APB represent the conclusion of at least two-thirds of the members of the APB, and as promulgated must be applied in all circumstances. Thus, once adopted, APB 26 defined accrual accounting treatment for bond defeasance costs.

the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services furnished." 42 C.F.R. § 413.24(b)(1). Section 413.24 requires the "recasting" of reported provider data and requires that the recasting be performed using approved methods of cost finding and the accrual basis of accounting.

The Petitioner's argument that the court of appeals erred in concluding that the Secretary is required to apply GAAP in adjudicating Medicare reimbursement claims in the absence of a specific regulation to the contrary is inconsistent with the position taken by the Secretary in those cases in which GAAP supports the Petitioner's position. For example, in *HCA Health Services of Midwest, Inc. v. Bowen*, 869 F.2d at 1180, "[t]he Secretary refused reimbursement on the ground that under 'generally accepted accounting principles' *(which the Secretary is mandated to apply where an issue has not been covered by agency regulations, 42 C.F.R. § 405.405* [42 C.F.R. § 413.60]) there were no reasonable costs incurred." (emphasis added) The decision in that case also observed that "[b]oth parties agree that in the absence of any promulgated regulations on this subject, the Secretary was correct to apply 'generally accepted accounting principles.' " *Id.* at 1181. Thus, Petitioner's position in this action is not only inconsistent with the Medicare cost reimbursement regulations but also with Petitioner's prior interpretation of those regulations.

The Petitioner's argument that the reimbursement of a loss on advance refunding in a single year will result in cross-subsidization by Medicare of non-Medicare patients is without merit and has been consistently rejected by the

courts. As explained by the court in *Mercy Hosp., supra*, at 12:

> The Secretary's cross-subsidization argument rests on a faulty premise. The regulations cited by the Secretary relate to reasonableness of claimed costs. There has been no allegation that the Hospital has not properly allocated the claimed costs between Medicare and non-Medicare patients. The parties have agreed that the costs are reasonable and the only outstanding issue is timing: when should reimbursement be made.

The PRRB also has explained that the loss on advance refunding relates solely to patient care in the year of defeasance, and thus gives rise to no cross-subsidizations between periods:

> The loss was related to patient care in the year of defeasance. The Board majority finds that the loss resulted from a change in the current market value of the debt. Market value of debt is determined by the market rate of interest. Had the market value of the debt been recorded in the Provider's books as the market rate of interest fluctuated, the changes in the market value of the debt would have been recorded periodically as losses or gains. Thus, there would have been no loss on the extinguishment of the debt. For that reason, the entire loss on defeasance should be recorded when the bond contract is terminated, because it relates to past periods when the bond contract was in effect.

Fort Worth Osteopathic Medical Ctr., supra, at 31,844-31,845.

The Petitioner relies on the cost allocation principles underlying asset depreciation and amortization to support her cross-subsidization argument. The Petitioner's reliance is misplaced. In the case of depreciation and amortization of capital assets, there is an asset on the books of the provider. The cost of using that asset is spread over the periods during which that asset remains on the books of the provider. There is no accepted accounting practice that would permit capitalizing and then amortizing an asset that is no longer in the possession of the provider or a liability that is no longer the obligation of the provider.

The Petitioner also appears to imply, at footnotes 11 and 13 of the Petition for a Writ of Certiorari, that the accrual accounting principles of APB 26, as applied by the court below, are inappropriate in the context of a government health care cost reimbursement program. The Petitioner cites Statements of the Governmental Accounting Standards Board in support of her position. The Statements of the Government Accounting Standards Board have no relevance to the issues of this case. Those standards apply only to government institutions, which sometimes use a cash basis of accounting rather than an accrual basis of accounting. The Medicare regulations provide for an exception to accrual accounting for certain governmental institutions at 42 C.F.R. § 413.24(a), as follows:

> However, if governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

It is undisputed that Respondent is not a governmental institution. Accrual accounting principles, rather than the cash accounting principles of the Statements of the Government Accounting Standards, govern reimbursement of Respondent's costs. Thus, Petitioner's reliance on the Statements of the Government Accounting Standards Board is misplaced.

PRM 233 Is a Substantive Rule That Was Promulgated Without Complying With the APA Rule-Making Requirements

The Petitioner's argument that PRM 233 is an interpretative rule, rather than a substantive rule, is based upon the assumption that 42 C.F.R. §§ 413.20 and 413.24 do not require adherence to GAAP for purposes of Medicare reimbursement. This assumption is not supported by the language of those regulations or of 42 C.F.R. § 413.5, and is not supported by the overwhelming weight of the decisional law interpreting those regulations in advance refunding transactions, as discussed above. Even if, however, the Petitioner's assumption were accepted, PRM 233 would constitute a substantive rule because its amortization treatment of advance refunding losses departs from the accrual basis of accounting required by 42 C.F.R. §§ 413.5, 413.20, and 413.24.

The Petitioner argues that PRM 233 is merely interpretative of the capital-related cost reimbursement provisions of 42 C.F.R. §§ 413.9, 413.130, and 413.153. The Petitioner made a similar argument in *The Methodist-Evangelical Hosp., Inc., supra*, at 6, as follows:

> The Secretary contends that the departure of the Section 233 amortization requirement from GAAP merely interprets existing regulations. She points to 42 C.F.R. §§ 413.5 and 413.9, which tie reimbursement generally to the actual cost of caring for Medicare beneficiaries in a single year, as well as § 413.153 on reimbursement of interest expense.

In rejecting this argument the court in *The Methodist-Evangelical Hosp.* applied the following four-part test from *American Mining Congress v. Mining Safety & Health Admin.*, 995 F.2d 1106, 1112 (D.C. Cir. 1993), for determining whether a rule is interpretive or substantive:

> (1) whether in the absence of the rule there would not be an adequate legislative basis for enforcement action or other agency action to confer benefits or ensure the performance of duties, (2) whether the agency has published the rule in the Code of Federal Regulations, (3) whether the agency has explicitly invoked its general legislative authority, or (4) whether the rule effectively amends a prior legislative rule. If the answer to any of these questions is affirmative, we have a legislative, not an interpretive rule.

The court in *The Methodist-Evangelical Hosp., Inc.* found that as to PRM 233 the first and the fourth of these questions must be answered in the affirmative, because, inter alia, "Section 233 also 'amends' §§ 413.20 and 413.24 by adding an exception to the application of generally accepted principles." *The Methodist-Evangelical Hosp., Inc., supra*, at 7.

This Court in *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979), defined a substantive rule as one "affecting individual rights and obligations." The Court described this characteristic as the "touchstone" for distinguishing between substantive and interpretative rules. *Id.* PRM 233 requires providers to amortize a loss on advance refunding over the remaining term of a debt, after the provider has been released of any further obligation on the debt. PRM 233 does not refer to any statutes or regulations authorizing its departure from accrual accounting principles, and the obligation it imposes on providers to defer their advance refunding loss is not imposed by any statute or regulation. Rather, PRM 233 creates a complicated set of new rules that alter the accounting treatment of the losses and gains incurred as the result of an advance refunding transaction. PRM 233 effects a fundamental change in accrual accounting principles. That change imposes record keeping and reporting obligations inconsistent with accrual accounting, defers the provider's right to reimbursement of current costs, and results in a decrease of current Medicare reimbursement, in Respondent's case in the amount of $314,000. Clearly, PRM 233 affects individual rights and obligations, thereby falling within the definition of substantive rule. See, *Mercy Hosp., supra*, at 16 ("These PRM sections [Sections 215, 215.1 and 233] substantively change the Secretary's accrual regulatory procedures into amortization procedures.").

The APA rule-making requirements for substantive rules are particularly applicable to Medicare rules used to determine reasonable costs. The Medicare statutory provision that defines "reasonable cost" provides that "[t]he

reasonable cost of any services . . . shall be determined *in accordance with regulations establishing the method or methods to be used*, and the items to be included, *in determining such costs* for various types or classes of institutions, agencies, and services. . . ." 42 U.S.C. § 1395x(v)(1)(A). (emphasis added) The reasonable cost regulations in effect at 42 C.F.R. Part 413 require the use of GAAP and accrual accounting principles. PRM 233 departs from GAAP and accrual accounting principles in the timing of reimbursement for advance refunding losses.

There is also a specific Medicare statute that requires the Secretary to proceed by rule making when prescribing substantive rules. 42 U.S.C. § 1395hh(a)(2) provides that:

> No rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment for services . . . under this subchapter shall take effect unless it is promulgated by the Secretary by regulation. . . .

This part of the statute was not in effect when PRM 233 was adopted by the Secretary. However, it indicated Congress' understanding that manual provisions such as PRM 233 that establish or change the legal standard or govern the payment for services are ineffective unless adopted pursuant to rule-making procedures.

The Decision of the Court Below Will Not Disrupt the Medicare Program

The Medicare regulations governing cost reimbursement require the use of the accrual basis of accounting and GAAP in determining the reimbursement of allowable costs. PRM 233 departs from the accrual basis of accounting and GAAP. The court below correctly determined that PRM 233 was inconsistent with existing Medicare regulations and therefore void. This holding is consistent with Medicare regulations and with relevant case law interpreting those regulations. Contrary to Petitioner's argument, there is no conflict among the courts of appeals on this issue.

The Petitioner would have this Court allow her to depart from accrual accounting principles and GAAP without complying with the APA rule-making procedures in this instance because substantial Medicare payments are at stake. This argument only undermines the Petitioner's argument that PRM 233 is not a substantive rule. The Petitioner's argument conclusively demonstrates that PRM 233 significantly impacts the rights of providers, and should be applied only after compliance with rule-making procedures.

The requirement that Petitioner proceed by rule making as provided by the APA is well-grounded and accepted by the courts. The notice and comment procedures have been found by the courts to help

> assure that the correct rules are established in the first instance. As this court has explained, "public participation assures that the agency will have before it the facts and information

> relevant to a particular administrative problem . . . [and] increase[s] the likelihood of administrative responsiveness to the needs and concerns of those affected."

American Hosp. Ass'n v. Bowen, 834 F.2d 1037, 1061 (D.C. Cir. 1987) (citations omitted). The *American Hosp. Ass'n* court further noted that rule making enables "the agency promulgating the rule to educate itself before establishing . . . procedures which have a substantial impact on those regulated." *Id.* (citation omitted).[7]

The effect of finding PRM 233 to be an interpretative rule would be to allow the Petitioner to avoid compliance with the APA and its rule-making requirements, as well as to avoid compliance with the accrual accounting requirements of the Petitioner's cost reimbursement regulations. The court below was correct in holding that the " 'Secretary may not promulgate regulations and then change their meanings by interpretations or clarifications without formal notice or comment.' " Sixth Circuit Decision, Appendix to Petition, 10a, quoting *Mercy Hosp. v. Sullivan, supra.*

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[7] *See also Chamber of Commerce of the United States v. OSHA*, 636 F.2d 464, 470 (D.C. Cir. 1980) ("Prior notice and an opportunity to comment permit [affected parties] to voice their objections before the agency takes final action," and "public scrutiny and participation before a legislative rule becomes effective can reduce the risk of factual errors, arbitrary actions, and unforeseen detrimental consequences").

CONCLUSION

The decision of the court below is consistent with the Medicare statutes and regulations and with the rule-making requirements of the APA. The decision of the court below is not in conflict with the decision of any other court of appeals, but instead is supported by the overwhelming weight of authority. The Petition for a Writ of Certiorari should be denied.

Respectfully submitted,

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